MVZ St. Marien Amberg, Praxis für Radiologie

Facharzt für Diagn. Radiologie, Mariahilfbergweg 7, 92224 Amberg
Tel. 09621 – 384080, **Fax** 09621 – 384144

Questionnaire for the

Magnetic resonance tomography

Patient's name Date of birth

Please answer conscientiously the following questions that apply to the patient. This will help us to recognize and prevent possible risks. Doctor or nursing staff will be pleased to assist you in completing the questionnaire. Please mark answers with a cross, underline it or add information in the appropriate area.

1. Do you have a **cardic pacemaker** or an **artificial cardiac valve?** ☐ No ☐ Yes

2. Which complaints do you have in the region we will examine?

   _____

   Since when? _____

3. Is it because of an accident or perhaps because of the consequences of it? ☐ No ☐ Yes

4. Have you ever had a surgery in the region we will examine today? ☐ No ☐ Yes

   If yes, when? _____

5. Do you have an insulin pump or another medicine pump? ☐ No ☐ Yes

6. Are there any other implants in your body or parts made of ferrous metal? ☐ No ☐ Yes
   E.g. artificial limb, vessel artificial limb (stent), vessel clip, tooth implant, brace, neurostimulator, „spiral", implanted hearing aid, piercing, permanent make-up, metal splinter as a result of accidents or injuries, metal dust depositings caused through your employment (e.g. shrapnel) etc.
   If yes, what kind? _____

7. Have you ever had a surgery on the spine, head, heart or vascular system? ☐ No ☐ Yes
   If yes, kind and year of the surgery: _____

Please turn around →

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8. Have you ever had surgery because of a tumor? ☐ No ☐ Yes

   If yes, kind an year of the surgery: _____

9. Is there any history of malfuncions of the kidneys? ☐ No ☐ Yes

10. Do you have to take medication regularly? ☐ No ☐ Yes
    (thyroid tablets, diabetes or hypertension?)

    If yes, which? _____

11. Do you have any allergies? ☐ No ☐ Yes
    If yes, what kind? _____

12. Do you suffer from HIV or hepatitis? ☐ No ☐ Yes

13. Did you ever get a MRI with a contrast agent? ☐ No ☐ Yes

    If yes, did you have any allergic reactions? _____

14. Do you suffer from claustrophobia? ☐ No ☐ Yes

15. Your weight: _____ kg your height: _____ m

16. Please tell us your phone number _____

17. Who is you family doctor? _____

18. **For women:** Could you be pregnant? ☐ No ☐ Yes

Consent

I have read and answered conscientiously the questions. I agree to the examination and i received counselling about the treatment with contrast solution and I agree for procedures.

Place, date Signature